



DIA Board # _____ (Required)

OEVR Form #152 Page 1 of 2

AMENDMENT, SUSPENSION, OR CLOSURE OF VOCATIONAL REHABILITATION

Check One: **AMENDMENT** ☐ **SUSPENSION** ☐ **CLOSURE** ☐

Employee: _____ DIA Board #: _____

Street Address: _____

City, State, Zip: _____

Adjuster: _____

VR Provider: _____

Address: _____

VR Specialist: _____ Tel. Number: _____

Vocational Goal: _____ DOT Code: _____

Complete the following if you are AMENDING OR SUSPENDING the VR plan:

1. Reason for Amendment.Suspension: _____

2. Proposed Amendment to Plan (attach other sheet if needed): _____

3. Additional VR Services and costs that are required:

SERVICES	FROM	TO	ESTIMATED COST
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Signatures

Employees' signature: _____ Date: _____

VR Specialist: _____ Date: _____

Insurer's Rep: _____ Date: _____

OEVR Rehab Review Officer: _____ Date: _____



**THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF INDUSTRIAL ACCIDENTS**

Office of Education and Vocational Rehabilitation
1 Congress St. Suite 100, Boston Massachusetts 02114
Information Line (800) 323-3249 ext. 280 in Massachusetts
(617) 727-4900 ext. 280 Outside Massachusetts
<http://www.mass.gov/dia/oevr>

DIA Board # _____ (Required)

OEVR Form #152 Page 2 of 2

Complete the following if you are CLOSING the Rehabilitation Plan:

Complete the following if the employee is working;

- ___ Returned to Work with same employer, modified job.
- ___ Returned to Work with same employer, different job.
- ___ Returned to Work with different employer, similar job.
- ___ Returned to Work with different employer, different job.
- ___ Retrained, Returned to Work with same employer.
- ___ Retrained, Returned to Work with different employer

If employer is different from former employer, please complete the following:

Employer Name: _____

Address: _____

Return to Work Date: _____ Hourly Wage \$ _____ AWW \$ _____

Has Employee been continuously employed for 60 days: Yes [] No []

Occupational Title: _____ DOT Code: _____

VR Provider Expenses (voc. Testing, TSA, C&G, etc): \$ _____

Other VR expenses- tuition, fees, B/S, transportation, etc): \$ _____

Total VR Costs: \$ _____

REASON FOR CLOSURE (check all that apply):

CLOSURE DATE: _____

- | | |
|---|-------------------------------|
| 1. ___ Medical condition precludes rehabilitation | 7. ___ Employee is Relocating |
| 2. ___ Not likely to benefit from further rehabilitation | 8. ___ Non- cooperation |
| 3. ___ RTW on own accord prior to finalized IWRP | 9. ___ Other (explain) _____ |
| 4. ___ Retired or deceased | _____ |
| 5. ___ IWRP services completed w/o RTW – Plan expired | _____ |
| 6. ___ IWRP services completed: rehabilitation successful | _____ |

Note: Upon completion of form, please sign on the front!